RULE

Department of Health
Board of Medical Examiners

Uniform Prescription Drug Prior Authorization Form
(LAC 46:XLV.8001 and 8003)

The Louisiana Administrative Procedure Act, R.S. 49:950 et seq., pursuant to the authority of the Louisiana Medical Practice Act, R.S. 37:1261 et seq., the Louisiana State Board of Medical Examiners (Board) has adopted a new Rule establishing the Louisiana Uniform Prescription Drug Prior Authorization Form. This rule-making effort is required by Act 423, of the 2018 Regular Session of the Legislature, and is in collaboration with the Louisiana Board of Pharmacy. This Rule is hereby adopted on the day of promulgation. The Rule is set forth below.

Title 46
PROFESSIONAL AND OCCUPATIONAL STANDARDS
Part XLV. Medical Professions
Subpart 3. Practice
Chapter 80. Louisiana Uniform Prescription Drug Prior Authorization Form
Subchapter A. General Provisions

§8001. Louisiana Uniform Prescription Drug Prior Authorization; Requirements; Referral for Enforcement

A. A prescriber or pharmacy required to obtain prior authorization from a third party payor shall complete the Louisiana Uniform Prescription Drug Prior Authorization Form referenced below in §8003, either in written form or its electronic equivalent.

B. In the event a third party payor demands the completion of an alternative authorization process, the prescriber or pharmacy shall refer the demand to the appropriate enforcement agency.

1. If the demand is made by a Medicaid-managed care organization, the prescriber or pharmacy shall refer the demand to the Department of Health.

2. If the demand is made by any other third party payor, the prescriber or pharmacy shall refer the demand to the Department of Insurance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1006.1(C) and 46:460.33(B).

HISTORICAL NOTE: Promulgated by the Department of Health, Board of Medical Examiners, LR 44:2154 (December 2018).

§8003. Louisiana Uniform Prescription Drug Prior Authorization Form

LOUISIANA UNIFORM PRESCRIPTION DRUG PRIOR AUTHORIZATION FORM

SECTION I - SUBMISSION

Submitted to:	Phone:	Fax:	Date:

SECTION II - PRESCRIBER INFORMATION

Last Name, First Name MI:		NPI# or Plan Provider #:	Specialty:		
Address:		City:		State:	ZIP Code:
Phone:	Fax:	Office Contact Name:	Contact Phone:		

SECTION III - PATIENT INFORMATION

Last Name, First Name MI:	DOB:	Phone:	☐ Male ☐ Female ☐ Other ☐ Unknown
Address:	City:	State:	ZIP Code:
Plan Name (if different from Section I):	Member or Medicaid ID #:	Plan Provider ID:	

Patient is currently a hospital inpatient getting ready for discharge? ____ Yes ____ No Date of Discharge:_____
Patient is being discharged from a psychiatric facility? ____ Yes ____ No Date of Discharge:_____
Patient is being discharged from a residential substance use facility? ____ Yes ____ No Date of Discharge:_____
Patient is a long-term care resident? ____ Yes ____ No If yes, name and phone number:_____
EPSDT Support Coordinator contact information, if applicable:

SECTION IV - PRESCRIPTION DRUG INFORMATION

Requested Drug Name:						
Strength:	Dosage Form:	Route of Admin:	Quantity:	Days' Supply:	Dosage Interval/Directions for Use:	Expected Therapy Duration/Start Date:

To the best of your knowledge this medication is: _____New therapy/Initial request
_____Continuation of therapy/Reauthorization request

For Provider Administered Drugs only:

HCPCS/CPT-4 Code:_____NDC#:_____Dose Per Administration:_____

Other Codes:_____

Will patient receive the drug in the physician's office? ____Yes ____No

– If no, list name and NPI of servicing provider/facility: _____

SECTION V - PATIENT CLINICAL INFORMATION

Primary diagnosis relevant to this request:	ICD-10 Diagnosis Code:	Date Diagnosed:
Secondary diagnosis relevant to this request:	ICD-10 Diagnosis Code:	Date Diagnosed:

For pain-related diagnoses, pain is: _____Acute _____Chronic
For postoperative pain-related diagnoses: Date of Surgery_____

Pertinent laboratory values and dates (attach or list below):

Date	Name of Test	Value

SECTION VI - THIS SECTION FOR OPIOID MEDICATIONS ONLY

Does the quantity requested exceed the max quantity limit allowed? ___Yes ___No (If yes, provide justification below.)
Cumulative daily MME_____
Does cumulative daily MME exceed the daily max MME allowed? ___Yes ___No (If yes, provide justification below.)

	YES (True)	NO (False)		THE PRESCRIBER ATTESTS TO THE FOLLOWING:
SHORT AND LONG-ACTING OPIOIDS			A	A complete **assessment** for pain and function was performed for this patient.
			B	The patient has been **screened for substance abuse / opioid dependence**. (Not required for recipients in long-term care facility.)
			C	The **PMP** will be accessed **each** time a controlled prescription is written for this patient.
			D	A **treatment plan** which includes current and previous goals of therapy for both pain and function has been developed for this patient.
			E	**Criteria** for failure of the opioid trial and for stopping or continuing the opioid has been established and explained to the patient.
			F	**Benefits and potential harms** of opioid use have been discussed with this patient.
			G	An **Opioid Treatment Agreement** signed by both the patient and prescriber is on file. (Not required for recipients in long-term care facility.)
LONG-ACTING OPIOIDS			H	The patient requires continuous **around the clock** analgesic therapy for which alternative treatment options have been inadequate or have not been tolerated.
			I.	Patient previously utilized at least two weeks of short-acting opioids for this condition. Please enter drug(s), dose, duration and date of trial in pharmacologic/non-pharmacologic treatment section below.
			J.	Medication has **not** been prescribed to treat acute pain, mild pain, or pain that is not expected to persist for an extended period of time.
			K	Medication has **not** been prescribed for use as an as-needed (PRN) analgesic.
			L.	Prescribing information for requested product has been **thoroughly reviewed** by prescriber.

IF NO FOR **ANY** OF THE ABOVE (A-L), PLEASE EXPLAIN:

SECTION VII - PHARMACOLOGIC & NON-PHARMACOLOGIC TREATMENT(S) USED FOR THIS DIAGNOSIS (BOTH PREVIOUS & CURRENT):

Drug name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason
Drug Allergies:			Height (if applicable):	Weight (if applicable):
Is there clinical evidence or patient history that suggests the use of the plan's pre-requisite medication(s), e.g. step medications, will be ineffective or cause an adverse reaction to the patient? ____Yes ____No (If yes, please explain in Section VIII below.)				

SECTION VIII - JUSTIFICATION (SEE INSTRUCTIONS)

By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge. Also, by signing and submitting this request form, the prescriber attests to statements in the 'Attestation' section of the criteria specific to this request, if applicable.

Signature of Prescriber:_____ Date:_____

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1006.1(C) and 46:460.33(B).

HISTORICAL NOTE: Promulgated by the Department of Health, Board of Medical Examiners, LR 44:2155 (December 2018).

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